STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner **File No. 120209-001**

v

Blue Care Network of Michigan

Respondent

Issued and entered
this 31st day of October 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On March 23, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of the Office of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The request for review concerns a claims denial issued by her health maintenance organization, Blue Care Network of Michigan (BCN).

The Commissioner notified BCN of the request and furnished the information used in issuing its claims denial. The Commissioner received material from BCN on March 28 and March 30, 2011. On March 30, 2011, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

Initially, this case appeared to involve only contractual issues. Upon further evaluation, the Commissioner determined this case would benefit from analysis by an independent medical review organization (IRO). An IRO was assigned and its analysis and recommendations were submitted to the Commissioner on October 3, 2011. A copy of the report is being provided to the parties with this Order.

II. FACTUAL BACKGROUND

The Petitioner receives her health care benefits under the *Blue Care Network BCN 10 Certificate of* Coverage (the certificate). Her effective date of coverage was March 15, 2010. Her certificate includes a pre-existing conditions clause that excludes coverage for any condition for which a covered person sought advice or treatment within the six-month period prior to the effective date of coverage.

On April 12, 2010, the Petitioner sought emergency care at XXXXX Hospital in XXXXX for weakness and dizziness. She was diagnosed with high blood pressure. She had a follow-up office visit with her primary care physician on April 13, 2010, and was prescribed amlodipine for hypertension and meclizine for vertigo. Her symptoms returned on April 14 and she went to the same hospital emergency department. She was found to be having a reaction to the meclizine. Petitioner's symptoms returned again on April 22. She went to XXXXX Urgent Care and was told she was having a reaction to her amlodipine, not meclizine. Her prescription for hypertension medication was changed to atenolol. Her symptoms did not return after that time.

BCN initially paid the claims for the Petitioner's emergency department treatment but later sought to recover its payments from the providers, having concluded that Petitioner had been treated for a pre-existing condition.

The Petitioner asked BCN to reprocess the claims and make payments to her providers, but BCN declined. The Petitioner appealed and, after exhausting BCN's internal grievance process, received its final adverse determination letter dated January 28, 2011.

III. ISSUE

Did BCN properly deny coverage for the care the Petitioner received on April 14, 2010, under the pre-existing conditions provision of the certificate?

IV. ANALYSIS

Petitioner's Argument

The Petitioner states she has a history of hypertension since 2008 and was prescribed medication to control the condition. The Petitioner asserts that she had discontinued use of the medication a couple of months prior to enrolling with BCN because she was living a healthier lifestyle.

On March 31, 2010, the Petitioner had an initial office visit with her BCN primary care doctor. The Petitioner states she thought the hypertension condition was under control because her new doctor did not prescribe hypertension medication during her initial office visit.

The Petitioner argues that BCN should reprocess the claims for the April 14, 2010, emergency room visit because the treatment she received was for a negative reaction to the hypertension medication not for treatment of hypertension.

Respondent's Argument

In its final adverse determination BCN described the claims in dispute. The April 14, 2010, claims were filed by XXXXX Hospital ($47.40) and by Dr. XXXXX ($182.98). BCN explained its reason for denying the Petitioner's claims:

> OneBlue has a pre-existing condition clause, stating that during the first six month period following the effective date, you will not be covered for any condition for which medical advice, diagnosis, care or treatment was recommended or received within 6 months before your enrollment. . . .
>
> . . . [T]he services were related to your pre-existing condition of hypertension. Therefore, you remain responsible for these costs; as well as the cost for any services you may have received through September 15, 2010 that were related to your hypertension.

Commissioner's Review

The BCN *OneBlue* enrollment application contains the following pre-existing conditions clause that was signed by the Petitioner:

> I understand that during the six month period following the effective date, my enrolled family members and I will not be covered for any and all conditions for which medical advice, diagnosis, care or treatment was recommended or received within 6 months before my enrollment. The term "conditions" includes, but is not limited to, maternity care, obstetrical care, and termination of pregnancy. I understand that my enrollment date begins on the effective date of coverage as determined by Blue Care Network.

To answer the question of whether the services the Petitioner received on April 14, 2010, were for a condition "for which medical advice, diagnosis, care, or treatment was recommended or received" within 6 months before enrollment, the Commissioner obtained the analysis of an independent review organization (IRO) as required by Section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6). The IRO reviewer is a physician in active practice;

certified by the American Board of Internal Medicine, with a subspecialty in cardiovascular disease; and certified by the National Board of Echocardiography, with a special competence in adult echocardiography. The IRO reviewer's report provided the following analysis and conclusion:

> The services provided April 13, 2010 through April 14, 2010 cannot totally be attributed to the pre-existing HTN [hypertension] condition. Certainly some of the symptoms could be attributable to hypertensive urgency, vertigo and/or a side effect to Meclizine. Any or a combination of these problems could be the potential etiology for her symptoms. Multiple providers had different opinions about her symptoms. The primary care physician felt she experienced both vertigo and hypertensive urgency. The ER physician felt the symptoms were secondary to both hypertension and a side effect of Meclizine. Unfortunately there is no diagnostic test to differentiate the etiology. Consequently, it is not possible to attribute a cause to the services provided on April 14, 2010. Therefore, the denial of coverage for date of service April 14, 2010 should be overturned.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO's recommendation is afforded deference by the Commissioner. In a decision to uphold or reverse an adverse determination, the Commissioner must cite "the principal reason or reasons why the Commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16)(b). The IRO's analysis is based on extensive experience, expertise and professional judgment. The Commissioner can discern no reason why the IRO's recommendation should be rejected in the present case. The Commissioner accepts the conclusion of the IRO and finds that Petitioner's emergency room visit on April 14, 2010, was not due to a pre-existing condition of hypertension.

The Commissioner finds that BCN's denial of coverage for the April 14, 2010, emergency room visit was not consistent with the terms of the certificate.

V. ORDER

The Commissioner reverses Blue Care Network of Michigan's final adverse determination of January 28, 2011. BCN shall provide coverage for the April 14, 2010, emergency room visit within 60 days of the date of this Order and shall, within seven (7) days of providing coverage, furnish the Commissioner with proof it has implemented this Order.

To enforce this Order, the Petitioner may report any complaint regarding implementation to the Office of Financial and Insurance Regulation, Health Plans Division, toll free (877) 999-6442.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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